

The authors describe a small study of old people (aged 70 or over) living at home. The aims of the study were quite simple: to estimate the prevalence of hearing impairment and mental state in elderly people at home. Using audiometric techniques to assess hearing impairment the authors report that the prevalence of deafness was twice that found in other studies which used either clinical assessment or self-reporting techniques.

This article has important implications for diagnosing and managing mental disorders in the elderly living in the community. The use of structured instruments in both research and clinical practice to assess mental state are usually unsuitable for use with deaf people or people with impaired hearing. Since, as this study shows, both deafness and mental state, particularly dementia, are related to old age, the validity of these methods of measuring mental state must be questioned.

COMMENT

It was encouraging to read about a successful piece of research which not only pushes forward the frontiers of knowledge but also has direct relevance to the health policy of old people.

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NOTE

- 1 Bond, J., Brooks, P., Carstairs, V. and Giles, L., The reliability of a survey psychiatric assessment schedule for the elderly, *British Journal of Psychiatry*, 137, 1980, 148–62.

Psychology and Psychiatry

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The articles selected for consideration here were not chosen randomly, nor were they selected because they represent the 'best' work by psychologists and psychiatrists published in 1980. Instead, they were chosen to exemplify the different methods employed in the study of psychological problems. The first is an example of a laboratory study of cognitive functioning. The second demonstrates the use of survey methods with a subgroup or 'minority' sample, while the third combines an observational and interventionist approach.

Ferris, S. H. Crook, T., Clarke, E., McCarthy, M. and Rae, D., 'Facial recognition memory deficits in normal ageing and senile dementia', *Journal of Gerontology*, 1980, 35, 66. 707-14.

The main objective of the experiment reported in this paper was to investigate loss of long-term memory ability in normal and cognitively impaired elderly subjects. There is evidence to support both the view that older subjects have as good a memory for verbal materials as younger subjects, and the view that there is impairment in verbal memory in elderly subjects. Impaired memory performance in the elderly is often attributed to fear of making an incorrect response and, hence, greater cautiousness.

Applying Signal Detection Theory methods to the study of memory loss in the elderly sheds some light on the nature of the loss. In verbal recognition memory tasks it has been shown that elderly subjects are more likely to say they have seen an item before, i.e., to respond 'old' to a new stimulus, leading to a high 'hit rate' and at the same time an increase in the 'false alarm' rate. An inflated false alarm rate is, as noted by Ferris *et. al.*, inconsistent with the view that elderly subjects do less well on recognition memory tests because of greater cautiousness.

Using Signal Detection Theory methods (the 'd' statistic in particular) enables the researcher to measure the ability of subjects to discriminate a signal, or 'old' item, from distractor items. Thus, it is possible to demonstrate that the elderly do as well as younger subjects if 'correct' responses (hits) only are analysed, but show poorer performance if false alarm rates are analysed. The same is true for cognitively impaired subjects.

Besides telling us (using Signal Detection Theory methods) *why* elderly subjects do less well on memory tasks, this study investigates *where* in the memory processing sequence a deficit is likely to occur. Thus, a recognition, instead of a recall, task was selected to test for loss at the encoding or storage stages, rather than at retrieval.

A face recognition task was chosen in order to investigate memory for non-verbal material. The authors argue that a facial memory task is a non-verbal task because there is evidence that right cerebral hemisphere lesions produce an impairment in facial memory, leaving verbal memory intact. Because the left hemisphere is believed to process mainly verbal information, facial recognition is most likely to be a non-verbal task of the right hemisphere. The experiment reported in this paper was directed to non-verbal memory because, to date, we know almost nothing about recognition memory for non-verbal material in the elderly.

A continuous recognition paradigm was utilized (the authors claim uniqueness for their experiment by noting that this paradigm has not been used to study facial recognition) with three groups of subjects. Group I

consisted of Young Normals (YN), Group II Elderly Normals (EN) and Group III, Elderly Impaired (EI) subjects. The EI subjects had been diagnosed as suffering from senile dementia. Individual male and female faces, on black and white slides, were projected automatically onto a screen and were viewed at eye level. The subjects pressed a 'yes' or 'no' button to indicate if the face had been seen before. The slide sequence was arranged with time delays of .5, 1, 2 or 4 minute intervals between first and second presentation. In addition, a long delay task was conducted 40 minutes following the first set of trials. The time delay was used in order to plot a memory decay curve as a function of time or interference.

Without taking into account false alarm rates, there were no group differences in recognition. But, there were statistically significant group differences in false alarm rates. The EI and EN groups made more false alarms than the Young Normals. The impaired and normal elderly subjects did not differ in false alarm rates.

For all groups there was a statistically significant change in recognition performance as a function of delay interval, with all groups showing a decline in performance by 4 minutes and a further decline by 40 minutes. The performance of the two elderly groups was below that of the Young Normals. The Young Normals showed greater cautiousness, i.e. less guessing, than the elderly subjects, although the difference between the three groups was not statistically significant.

Thus, the authors claim that the results of this experiment lead to the conclusion that facial recognition memory declines with normal ageing, but there is no additional decline due to mild or moderate cognitive impairment.

COMMENT

The most interesting finding of this study was that the cognitively impaired subjects did no worse than the normal elderly subjects on the facial recognition task. As this is not exactly a finding that one might predict, it would have been useful if the authors had made an attempt to explain why the performance of the two groups was equivalent. Also, time could have been spent discussing what a finding like this tells us about senile dementia.

Although I thought the experiment was well designed, I had doubts about the reference throughout the paper to 'right hemisphere recognition'. The faces were not directed to the right or left hemispheres (right or left visual field presentation), so we have no real way of knowing that the processing of the faces took place in the right hemisphere. It is quite possible that the subjects examined the slides and gave them verbal labels,

for example, 'man with long nose and moustache'. Thus, the results demonstrate a deficit in facial recognition memory, but we cannot be sure, as the authors claim, that there is a 'right hemisphere memory deficit due to normal ageing'.

Bennet, K. C. and Thompson, N. L., 'Social and psychological functioning of the ageing male homosexual', *British Journal of Psychiatry*, 1980, 137, pp. 361-70.

The authors begin by noting that there is a negative, almost pathetic stereotype of the older homosexual which can be appreciated by considering terms commonly in use such as 'old aunties', 'old queens' and 'menopausal queens'. This is thought to have the following genesis, (1) the loss of physical attractiveness forces the older homosexual to disengage from the homosexual subculture, (2) the more isolated he becomes from homosexual life, the more he is forced to develop associations with heterosexuals, and (3) because of (1) and (2) the more subject he is to loneliness, unhappiness and reduced self-esteem.

While some recent research shows that the social functioning of the older male homosexual is better than the stereotype would suggest, homosexuals do face problems associated with ageing. Thus, the aim of the study was to examine adjustments made by homosexual men of various ages, and to separate age variations in functioning from other variables.

An 18-page questionnaire eliciting information was completed by 478 Australian men who claimed to be homosexual. Areas covered included demographic variables, psychiatric treatment, social involvement in homo- and hetero-sexual circles, same and opposite-sex histories, homosexual identity, self-esteem and the respondent's perceived acceptance by others of his homosexuality. The respondents were volunteers and were recruited from Sydney gay bars, two nationwide gay religious organizations, college and university gay groups, gay social organizations, a gay newspaper, friendship circles and personal contacts. The age range was 16 to 74 years.

The variable 'age' was divided into four categories, (1) 25 years and less, (2) 26-35 years, (3) 36-45 years, and (4) 46 years plus. Chi squares and multivariate analyses of covariance were conducted. The analyses revealed the following:

The older homosexual male was as involved in the homosexual world as the younger man. There was, for example, as much visiting of gay bars and clubs among the older, as compared with the younger men. The older homosexual reported being just as satisfied with his involvement in the gay community as the younger homosexual. The older respondents were found to be in either a long-term relationship or none at all. The authors

think that it may be more difficult, when older, to find a new partner, or the older man may be more discerning and careful about rushing into a relationship.

There was no evidence to support the suggestion of an increase in contact with heterosexuals with age. Interestingly, the age group, 25–35 years, displayed less satisfaction with their heterosexual life than the other age groups. The authors suggest that gay men, by the time they reach age 40, have adjusted to both the homosexual and heterosexual life styles.

Where age differences were found they were in the management of a homosexual identity. The older men were more likely to ‘pass’ or conceal their homosexuality. The youngest group was significantly more likely to claim self-control over their homosexuality than any of the three older groups. Furthermore, those aged 25 years and less were also more likely to say that their sexual orientation was supported by significant others. On this third set of findings the authors comment that the differences are likely to be generational, rather than a reflection of the ageing process.

Overall, this survey provides little evidence to support the widespread belief that ageing had negative consequences for male homosexuals. The older man experienced (or reported) no more loneliness or unhappiness, and did not show a diminution of self-esteem. Nor did the old male homosexual show an increased worry about the ageing process.

Thus, the authors claim to provide some reassurance not only for young homosexuals who are anxious about growing old in the gay community, but for their parents as well.

COMMENT

My own naïveté attracted me to this article. Firstly, it had never occurred to me that homosexuals would experience ageing differently from the rest of the population. Secondly, my own stereotype of a ‘macho’ Australia is such that I did not believe that there were enough homosexual men in Australia – or enough willing to admit to being homosexual! – to conduct a survey of this sort.

Perhaps it was because I had given so little thought to the effects of ageing on a population like homosexuals that I found this article interesting and quite informative. However, it would have been even more interesting if Bennett and Thompson had been able to compare male and female homosexual adjustments to ageing.

Unfortunately, there is a rather serious flaw in the conclusions that Bennett and Thompson draw from the findings. The authors claim that the survey revealed that the older homosexual man was just as involved in the homosexual world and community as the younger homosexual, and

was just as satisfied with this involvement. This finding is hardly surprising in the light of *where* Bennett and Thompson got their sample – namely, gay bars, religious organizations, college groups, other homosexual organizations, plus friendship circles and personal contacts.

Davies, A. D. M. and Snaith, P. A., 'The social behaviour of geriatric patients at mealtimes: An observational and an intervention study', *Age and Ageing*, 1980, 9, pp. 93–9.

The project reported in this article was designed to examine the hypothesis that social withdrawal in geriatric patients in a long-term care ward is environmentally determined, rather than intrinsic to the patient. It consisted of two studies, one in which two geriatric wards were compared for levels of social interaction between patients and between patients and staff, and another in which the authors re-arranged the seating patterns in the ward found to have lower social interaction and then investigated the effect of the change on social interactions.

From 127 discrete instances of social interaction (an interaction was defined as 'an episode of actual or attempted communication between one individual and another'), a system of categorization of the interactions was developed using content analysis. Some of the categories developed included 'Staff concern for patient welfare', 'Patient-patient request', and 'Choice-staff initiated'.

On Ward A there was a total of 41 observed interactions; on Ward B 86 interactions were recorded. During the recording session no instance of a patient asking for help or information was noted on Ward A. On Ward B almost a third of all interactions were started by patients. The staff on Ward A were seen as more restricting and the ward sister was not observed in any social interaction during the meal. The 'ward atmosphere' on Ward A was felt, by the authors, to be different from that on Ward B. Although Ward A had more staff than Ward B (11 versus 8), twice as many interactions occurred and the variety of interactions was found to be greater.

The differences in social interaction were accounted for by the differences in ward layout. In Ward A, the ward with less interaction, the patients sat with their backs to the walls, with a row of wheelchairs lined across the centre of the dayroom. The lunch and cutlery trolleys were brought into the room. In Ward B (Ward B was smaller than Ward A) three groups of patients sat round tables, with the others noted to be in cramped conditions round the walls. The food trolley had to be kept in the corridor, which meant that noise levels during lunch were lower.

The intervention study was planned and designed to increase interaction on Ward A. Two lunch tables to seat six were introduced and set with cloths, water-jugs, etc. Food trolleys were moved into the corridor. Note, however, that only 12 of the 27 patients on Ward A were selected to take part in the new arrangement; we are not told why. At meal time on the day before the intervention observations were made of every dyadic social interaction. This procedure was repeated the second day after the ward change.

After the ward changes there was an increase in social interaction, both between patients and between staff and patients. However, in the case of staff-patient interaction, the interaction increase was due mainly to staff initiated interactions. A sociogram analysis also demonstrated that both previously sociable patients and isolates benefited from the environmental changes.

COMMENT

This very simple study quite adequately demonstrates the influence of ward design on social interaction. However, the design is so basic, and the hypothesis that social withdrawal is to a large extent environmentally determined so well supported (see, for example, Sommer, 1969, and Canter and Canter, 1979), that one is left wondering what contribution this paper makes to the literature.

Research like this provides the link between environmental psychology and social gerontology. Thus, Davies and Snaith could have made more use of concepts employed in environmental psychology, e.g. sociopetal and sociofugal space. Also, the paper would have been more exciting if the authors told us how the staff and patients on Ward A felt about the environmental manipulations. Like other literature in this area, it is an *a priori* judgement that opportunity for social interaction represents a desirable institutional quality. Finally, it would have been a good idea to have included a follow-up observational period at, say, three or six months to see if there was a return to pre-intervention interaction levels.

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NOTES

Canter, D. and Canter, S., *Designing for therapeutic environments: A review of research*, Chichester, John Wiley & Sons, 1969.

Sommer, R., *Personal space: The behavioural basis of design*, Englewood Cliffs, New Jersey, Prentice-Hall, 1969.